FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015032

Facility Name: WASHINGTON AND JANE SMITH COMMUNITY

Address: 2340 WEST 113 TH PLACE (Number) CHICAGO (City) 60643 (Zip Code)

County: COOK

Telephone Number: 773 779-8010 **Fax #** 773 779-8648

IDPA ID Number: 362167948001

Date of Initial License for Current Owners: 09/06/96

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) GARY JOHANSON

(Title) CEO AND PRESIDENT

Paid Preparer

(Signed) (Date)

(Print Name and Title) DANIEL L. MALONE (SOLE PRACTITIONER)

(Firm Name & Address) 133 S. OLD CREEK RD. PALOS PARK, IL 60464

(Telephone) 708 361-4295 Fax # 708 448-3228

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,404	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	185	Sheltered Care (SC)	185	67,710	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	102,114	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0		2,655	2,655	8
9	SNF/PED					9
10	ICF	11,802	68,021	3,307	83,130	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,802	68,021	5,962	85,785	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.01%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/24/26

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2440

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number WASHINGTON AND JANE SMITH COMM # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	400,439	6,048	670,995	1,077,482	(19,122)	1,058,360	0	1,058,360			1
2	Food Purchase							0				2
3	Housekeeping	255,650	59,552		315,202		315,202	0	315,202			3
4	Laundry	69,226	13,789		83,015		83,015	0	83,015			4
5	Heat and Other Utilities			260,918	260,918		260,918	(4,002)	256,916			5
6	Maintenance	197,193	24,098	165,933	387,224		387,224	0	387,224			6
7	Other (specify):* SECURITY GUARD			32,585	32,585		32,585	0	32,585			7
8	TOTAL General Services	922,508	103,487	1,130,431	2,156,426	(19,122)	2,137,304	(4,002)	2,133,302			8
	B. Health Care and Programs											
9	Medical Director							0				9
10	Nursing and Medical Records	1,790,635	112,717	200,927	2,104,279		2,104,279	0	2,104,279			10
10a	Therapy	26,075		211,769	237,844	(175,306)	62,538	0	62,538			10a
11	Activities	318,934	8,692	70,558	398,184		398,184	0	398,184			11
12	Social Services			3,020	3,020		3,020	0	3,020			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	2,135,644	121,409	486,274	2,743,327	(175,306)	2,568,021		2,568,021			16
	C. General Administration											
17	Administrative	165,913			165,913		165,913	0	165,913			17
18	Directors Fees							0				18
19	Professional Services			161,163	161,163		161,163	(74,771)	86,392			19
20	Dues, Fees, Subscriptions & Promotions			50,649	50,649		50,649		50,649			20
21	Clerical & General Office Expenses	301,931	40,234	114,525	456,690		456,690	(13,222)	443,468			21
22	Employee Benefits & Payroll Taxes			582,183	582,183	19,122	601,305		601,305			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			9,187	9,187		9,187	0	9,187			24
25	Other Admin. Staff Transportation			4,150	4,150		4,150	0	4,150			25
26	Insurance-Prop.Liab.Malpractice			146,118	146,118		146,118	0	146,118			26
27	Other (specify):*							0				27
28	TOTAL General Administration	467,844	40,234	1,067,975	1,576,053	19,122	1,595,175	(87,993)	1,507,182			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,525,996	265,130	2,684,680	6,475,806	(175,306)	6,300,500	(91,995)	6,208,505			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WASHINGTON AND JANE SMITH COMM # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			477,447	477,447		477,447	(53,619)	423,828			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			325,659	325,659		325,659	0	325,659			32
33	Real Estate Taxes			3,396	3,396		3,396	(3,396)				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			806,502	806,502		806,502	(57,015)	749,487			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers THERAPY COSTS FOR MEDICARE					175,306	175,306	0	175,306			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			52,149	52,149		52,149	0	52,149			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			52,149	52,149	175,306	227,455		227,455			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,525,996	265,130	3,543,331	7,334,457	0	7,334,457	(149,010)	7,185,447			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,576)	L21C3		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees MARKETING AND FEASIBILITY FEES	(56,515)	L19C3		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(646)	L21C3		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,256)	L19C3		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,396)	L33C3		26
27	Nurse Aide Training for Non-Employees				27
28	APARTMENTS' DEPREC EXPENSE	(53,619)	L30C3		28
29	Other-Attach Schedule APARTMENT BUILDING UTILITIES	(4,002)	L5C3		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (149,010)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (149,010)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name **WASHINGTON AND JANE SMITH COMMUNITY**

ID# **0015032**

Report Period Beginning: **07/01/99**

Ending: **06/30/2000**

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	0
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	(12,576)	L21C3	Line 5	0
6	Rented Facility Space	0	0	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	0
9	Non-Straightline Depreciation	0	0	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	0	0	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	(56,515)	L19C3	Line 16	0
18	Fines and Penalties	0	0	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	(646)	L21C3	Line 19	0
21	Owner or Key-Man Insurance	0	0	Line 20	0
22	Special Legal Fees & Legal Retainers	(18,256)	L19C3	Line 21	0
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	0	0	Line 23	0
25	Fund Raising, Advertising and Promotional	0	0	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	(3,396)	L33C3	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	(53,619)	L30C3	Line 27	0
29	Non-Paid Workers	0	0	Line 28	0
30	Donated Goods	0	0	Line 29	0
31	Amortization Expense	0	0	Line 30	0
32				Line 31	0
33				Line 32	0
34				Line 33	0
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	0
39				Line 38	0
40				Line 39	0
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NOT APPLICABLE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WASHINGTON AND JANE SMITH COM # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. NEMIC	BOARD MEMBER	PRESIDENT OF THE BOA	NONE	NONE	10	25.00	FINANCIAL	$ 58,859	L19COL. 3	1
2			AND OWNER OF					SERVICES			2
3			HERITAGE CAPITAL								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,859		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 6/30/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMM # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	ILLINOIS HEALTH FACILITIES AUTHORITY		X	MORTGAGE	N0NE	07/01/91	$ 5,800,000	$ 5,800,000	07/01/26	VARIABLE	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,800,000	$ 5,800,000			$	9
	B. Non-Facility Related*											
10	ILLINOIS HEALTH FACILITIES AUTHORITY		X	MORTGAGE	N0NE	07/01/97	1,000,000	1,000,000	09/15/02	VARIABLE		10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 1,000,000	$ 1,000,000			$	14
15	TOTALS (line 9+line14)						$ 6,800,000	$ 6,800,000			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 185,004 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	NURSING FACILITY	247,516	PRE 1994	649,404	2
3	TOTALS	#VALUE!		$ 649,404	3

Print Preview

Cell: N43
Comment: Formula failed to convert

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1924		$ 70,920	$	40	$	$	$ 70,920	4
5	57			1928	438,552		40			438,552	5
6	55			1958	429,080		35			429,080	6
7	50			1972	1,528,440	43,670	35	43,670	0	968,679	7
8	77			1992	4,868,578	139,102	35	139,102	0	1,112,816	8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	BUILDING IMPROVEMENTS			1972	307,827		20	0	0	307,827	9
10	BOILER AND VENTILATING			1974	48,223		20	0	0	48,223	10
11	BUILDING IMPROVEMENTS			1975	91,428		20	0	0	91,428	11
12	BUILDING IMPROVEMENTS			1978	205,755		20	0	0	205,755	12
13	BUILDING IMPROVEMENTS			1980	102,046	5,102	20	5,102	0	101,684	13
14	BUILDING IMPROVEMENTS			1981	31,819	1,591	20	1,591	0	30,228	14
15	BUILDING IMPROVEMENTS			1982	53,600	2,680	20	2,680	0	48,240	15
16	BUILDING IMPROVEMENTS			1983	163,759	8,188	20	8,188	0	139,196	16
17	BUILDING IMPROVEMENTS			1984	187,160	9,358	20	9,358	0	149,728	17
18	PARKING LOT			1984	3,580	179	20	179	0	2,864	18
19	BUILDING IMPROVEMENTS			1985	26,309	1,315	20	1,315	0	19,729	19
20	BUILDING IMPROVEMENTS			1987	149,405		10	0	0	149,405	20
21	BUILDING IMPROVEMENTS			1989	81,658		8	0	0	81,658	21
22	SMITH WING RENOVATION			1989	150,364	9,004	16.7	9,004	0	101,532	22
23	BUILDING IMPROVEMENTS			1991	160,090		8	0	0	160,090	23
24	KITCHEN REMODELING			1991	931,139	26,604	35	26,604	0	226,160	24
25	ROOF AND SIDING			1991	40,000	2,395	16.7	2,395	0	20,660	25
26	BUILDING IMPROVEMENTS			1993	69,928	4,187	16.7	4,187	0	31,622	26
27	FAN COIL PROJECT			1994	102,713	10,271	10	10,271	0	66,761	27
28	BUILDING REMODELING			1995	52,983	5,298	10	5,298	0	30,009	28
29	COMPLETE FAN COIL PROJECT			1995	217,546	8,702	25	8,702	0	47,861	29
30	ROOF			1996	14,045	1,405	10	1,405	0	7,024	30
31	ELEVATOR			1996	28,857	962	30	962	0	4,546	31
32	ROOF REPAIR			1997	118,147	11,815	10	11,815	0	41,352	32
33	BOILER PROJECT			1997	96,589	9,659	10	9,659	0	33,806	33
34	SIDEWALK PAVING			1997	9,968	997	10	997	0	3,489	34
35	GUTTER REPLACEMENT AND REPAIRS			1997	3,886	389	10	389	0	1,361	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 302,873		$ 302,873	$	$ 5,172,285	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONL	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	PAINTING AND ROOM DECORATING		1997	24,159	2,416	10	2,416	0	8,456	9	
10	BUILDING MAINTENANCE		1997	4,890	489	10	489	0	1,711	10	
11	WINDOW REPAIR AND REPLACEMENT		1997	14,192	1,419	10	1,419	0	4,967	11	
12	HEATING AND PLUMBING		1992	7,248	518	14	518	0	3,276	12	
13	HEATING AND PLUMBING		1993	7,935	794	10	794	0	5,161	13	
14	HEATING AND PLUMBING		1995	5,575	558	10	558	0	3,023	14	
15	AIR CONDITIONER AND VENTILATING		1995	4,874	244	20	244	0	1,544	15	
16	TELEPHONE SYSTEM		1996	22,211	2,221	10	2,221	0	8,884	16	
17	AIR CONDITIONER AND VENTILATING		1996	6,765	338	20	338	0	1,352	17	
18	SECURITY SYSTEM		1997	14,872	2,125	7	2,125	0	7,437	18	
19	SPRINKLER SYSTEM		1997	31,262	4,466	7	4,466	0	15,631	19	
20	AIR CONDITIONER AND VENTILATING		1997	28,183	1,409	20	1,409	0	4,932	20	
21	ARTS AND CRAFTS ROOM RENOVATIONS		1998	9,232	923	10	923	0	2,077	21	
22	AUDITORIUM RENOVATIONS		1998	8,159	816	10	816	0	2,108	22	
23	BOILER PROJECT		1998	2,123	212	10	212	0	601	23	
24	ELEVATOR		1998	88,086	4,440	20	4,440	0	12,183	24	
25	HEATING AND PLUMBING		1998	7,259	290	25	290	0	701	25	
26	LIGHTING UPGRADE		1998	57,526	3,196	18	3,196	0	7,457	26	
27	PHONE SYSTEM		1998	26,163	2,616	10	2,616	0	7,194	27	
28	ROOF REPAIR		1998	37,174	1,859	20	1,859	0	4,647	28	
29	SMOKE DETECTORS		1998	6,312	631	10	631	0	1,735	29	
30	KITCHEN REMODELING		1998	6,413	641	10	641	0	1,603	30	
31	AIR CONDITIONER AND VENTILATING		1998	2,815	563	5	563	0	1,689	31	
32	AIR CONDITIONER AND VENTILATING		1998	2,687	269	10	269	0	784	32	
33	ELECTRICAL FIXTURES FOR HALLWAYS		1998	1,106	111	10	111	0	314	33	
34	HEAD RAILS FOR HALLWAYS		1998	1,494	149	10	149	0	423	34	
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			$ #VALUE!	$ 33,713		$ 33,713	$	$ 109,890	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONL	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	MULTI PURPOSE ROOM			1999	8,834	442	20	442	0	479	9
10	CARPET IN THE FRONT HALLWAY			1999	7,756	388	20	388	0	485	10
11	AC MOTOR			1999	1,481	148	10	148	0	185	11
12	ELEVATOR REPAIR			1999	3,390	170	20	170	0	297	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 1,148		$ 1,148	$	$ 1,446	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 619,463	$ 70,597	$ 70,597	$ 0	7-20 YRS	$ 357,350	37
38	Current Year Purchases	85,217	12,425	12,425		7-20 YRS	12,425	38
39	Fully Depreciated Assets	619,547					619,547	39
40								40
41	TOTALS	$ 1,324,227	$ 83,022	$ 83,022	$		$ 989,322	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	NURSING FACILITY	1987 FORD VAN	1987	$ 23,800	$ 0	$ 0	$	5	$ 23,800	42
43	NURSING FACILITY	1986 CELEBRITY WAGON	1994	3,920	0	0		5	3,920	43
44	NURSING FACILITY	1999 FORD TAURUS	1999	16,118	1,612	1,612		10	1,175	44
45	NURSING FACILITY	1987 FORD F250 PICK UP	1998	7,300	1,460	1,460		5	1,460	45
46	TOTALS			$ 51,138	$ 3,072	$ 3,072	$		$ 30,355	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 423,828	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 423,828	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 6,191,962	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	APARTMENT BUILDING	$ 487,975	$ 12,199	$ 32,766	52
53	APARTMENT BUILDING IMPROVEMENTS	60,886	27,245	27,245	53
54	APARTMENT FURNITURE AND EQUIPMENT	27,252	3,837	3,837	54
55	LAND	112,500	0	0	55
56					56
57	TOTALS	$ 688,613	$ 43,281	$ 63,848	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 74,121	$		$ 74,121	1
2	Licensed Speech and Language Development Therapist		hrs			9,457			9,457	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			91,728			91,728	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 175,306	$		$ 175,306	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 86,846	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,162,195		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,200		6
7	Other Prepaid Expenses	65,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): OTHER ACCOUNTS REC.	100,391		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,442,632	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	55,643,944		12
13	Land	761,904		13
14	Buildings, at Historical Cost	13,516,179		14
15	Leasehold Improvements, at Historical Cost	2,662,998		15
16	Equipment, at Historical Cost	2,161,083		16
17	Accumulated Depreciation (book methods)	(5,525,231)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	324,500		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRESS	741,719		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 70,287,096	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 71,729,728	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 564,208	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	212,847		30
31	Accrued Taxes Payable (excluding real estate taxes)	(126)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PENSION	149,074		36
37	SECURITY DEPOSIT	7,250		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 933,253	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,616,685		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	GIFT ANNUITIES	9,254		43
44	INTER FUND PAYABLE	411,012		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,036,951	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,970,204	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 63,759,524	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 71,729,728	$ 0	48

***(See instructions.)**

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 51,989,567	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 51,989,567	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,769,957	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 11,769,957	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 63,759,524	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNI # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,274,222	1
2	Discounts and Allowances for all Levels	(1,092,438)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,181,784	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	51,571	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 51,571	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	17,605	12
13	Barber and Beauty Care	45,215	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	12,576	15
16	Rental of Facility Space		16
17	Sale of Drugs	31,513	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	45,878	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 152,787	23
	D. Non-Operating Revenue		
24	Contributions	85,320	24
25	Interest and Other Investment Income***	1,029,872	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,115,192	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	3,207	28
28a	NET CAPITAL GAINS	11,599,873	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,603,080	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,104,414	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 2,137,304	31
32	Health Care	2,568,021	32
33	General Administration	1,595,175	33
	B. Capital Expense		
34	Ownership	806,502	34
	C. Ancillary Expense		
35	Special Cost Centers	175,306	35
36	Provider Participation Fee	52,149	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,334,457	40
41	**Income before Income Taxes (line 30 minus line 40)****	11,769,957	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 11,769,957	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,612	1,950	$ 57,644	$ 29.56	1
2	Assistant Director of Nursing	168	310	8,013	25.85	2
3	Registered Nurses	28,375	29,806	471,939	15.83	3
4	Licensed Practical Nurses	17,572	18,313	228,024	12.45	4
5	Nurse Aides & Orderlies	133,393	137,444	926,618	6.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,875	1,950	26,075	13.37	8
9	Activity Director	1,875	1,950	27,325	14.01	9
10	Activity Assistants	36,926	37,368	291,609	7.80	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,793	1,950	37,389	19.17	13
14	Head Cook	4,270	4,658	45,873	9.85	14
15	Cook Helpers/Assistants	31,190	32,540	226,652	6.97	15
16	Dishwashers	14,007	14,426	90,525	6.28	16
17	Maintenance Workers	18,364	19,754	197,193	9.98	17
18	Housekeepers	43,841	44,085	255,650	5.80	18
19	Laundry	9,163	9,575	69,226	7.23	19
20	Administrator	1,853	1,950	66,028	33.86	20
21	Assistant Administrator					21
22	Other Administrative	1,748	1,950	99,885	51.22	22
23	Office Manager					23
24	Clerical	21,188	22,416	301,931	13.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,668	3,900	80,082	20.53	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,940	2,105	18,315	8.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	374,821	388,400	$ 3,525,996 *	$ 9.08	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		9,138	L10C3	36
37	Medical Records Consultant		3,648	L10C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 12,786		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	8	216	L10 COL 3	51
52	Nurse Aides	57	1,230	L10 COL 3	52
53	TOTAL (lines 50 - 52)	65	$ 1,446		53

Print Preview

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Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNI # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROY EICHMAN	ADMINISTRATOR	NONE	$ 66,028
GARY JOHANSON	EXEC DIRECTOR	NONE	99,885
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 165,913

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
DESMOND AND AHERN	AUDITING	$ 7,114
FR & R CONSULTING	ACCOUNTING	8,474
DLM FINANCIAL ADVISORY SERV	ACCOUNTING	3,775
QUARLES AND BRADY	LEGAL	26,426
HERITAGE CAPITAL MGMT	INVESTMENT MGMT	58,859
VARIOUS MARKETING	SIGNUM	
AND FEASIBILITY FEES	AV POWELL, OWP&P	56,515
(NOTE: ALL MARKETING AND		
FEASIBILITY FEES		
HAVE BEEN ADJUSTED		
FROM THE COST		
REPORT- SEE PAGE 5)		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 161,163

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	5,032
FICA Taxes	258,808
Employee Health Insurance	116,873
Employee Meals	19,122
Illinois Municipal Retirement Fund (IMRF)*	
PENSION PLAN	200,640
OTHER EMPLOYEE BENEFITS	830
TOTAL (agree to Schedule V, line 22, col.8)	$ 601,305

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	500
(Indicate # of checks performed)	
LIFE SERVICES NETWORK	32,500
DUES AND SUBCRIPTIONS	13,844
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,844

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,188
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,188

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	NOT APPLICABLE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Preview

Facility Name & ID Number WASHINGTON AND JANE SMITH COMMUNITY # 0015032 Report Period Beginning: 07/01/99 Ending: 06/30/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? N0

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICES NETWORK ; 32,500

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ O Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 52,149
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? NONE

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 19,122 Has any meal income been offset against related costs? NONE Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: DESMOND & AHERN The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. AUDIT IS NOT COMPLETE

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

SUPPORTING SCHEDULES FOR THE COST REPORT

RECLASSIFICATIONS:

DESCRIPTION	AMOUNT	FROM: PAGE	FROM: LINE & COLUMN	TO: PAGE	TO: LINE & COLUMN
RECLASSIFY EMPLOYEE MEALS TO FRINGE BENEFITS	19,122	3	L1 COL 3	3	L22 COL 4
RECLASSIFY MEDICARE RELATED THERAPY SERVICES	175,306	3	L10a COL 3	3	L39 COL 4

SCHEDULE OF LEGAL EXPENSE AFTER ADJUSTMENT FOR UNRELATED EXPENSES:

VENDOR	AMOUNT	CHECK NO.	
QUARLES & BRADY	52.00		SERVICES RE: YEAR END AUDIT AND BOARD OF DIRECTORS MEETINGS
QUARLES & BRADY	23.00		CORPORATE REORGANIZATION; EMPLOYMENT AGREEMENTS
QUARLES & BRADY	423.00		
QUARLES & BRADY	4,449.00		
QUARLES & BRADY	1,065.00		
QUARLES & BRADY	1,426.00		
QUARLES & BRADY	83.00		
TOTAL	7,521.00		